UNITED STATES DISTRICT COURT

DISTRICT OF ALASKA

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KIMBERLY ALLEN, Personal Representative of the Estate of Todd Allen, Individually on Behalf of the Estate of Todd Allen and on Behalf of the Minor Child, PRESLEY GRACE ALLEN,	)	
Plaintiffs,	)	
vs.	)	NO. 3:04-CV-0131-JKS
UNITED STATES OF AMERICA,	)	
Defendant.	)	

VIDEOTAPED DEPOSITION OF

FRANK MANNIX, M.D.

CARDIFF BY THE SEA, CALIFORNIA

FEBRUARY 14, 2006

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FILE NO.: A000F65

14:03:39 An additional four hours?
14:03:41 A. Yes.
14:03:41 Q. All right.
14:03:42 And since the report was prepared up until now, can
14:03:44 you give me an idea, if you spent additional time, how much
14:03:48 time you've spent?
14:03:49 A. I have. It looks like, as what's been billed,
14:03:53 there's just another half hour. But probably in preparation
14:03:58 for today's deposition -- I could look upstairs if you want
14:04:04 me to, but it's in the area of six to eight hours. And then
14:04:07 we met this morning for about three hours. And here we are
14:04:12 now. So those are all pretty close.
14:04:14 Q. So six to eight hours, was that in reviewing
14:04:18 materials?
14:04:19 A. Again, and making sure that I was comfortable and
14:04:21 could access everything quickly in response to your
14:04:25 questions.
14:04:26 Q. And would the six, eight hours include reviewing
14:04:30 any of the reports from the defense experts?
14:04:33 A. I don't believe so. I believe I got those before,
14:04:35 but I'm not positive about that.
14:04:37 Q. All right.
14:04:38 And you said you met for three hours. Was that
14:04:42 with Ms. McCready?
14:04:43 A. It was, this morning, yes.

14:04:44 Q. And other than this morning, other than this
14:04:48 research on nuchal rigidity, were you given any additional
14:04:50 either information or documents this morning?
14:04:53 A. No. I verified that at the hospital in question,
14:04:57 there was not a neurosurgeon or neurosurgery available. And
14:05:01 she led me to believe that that's her understanding as well.
14:05:05 Q. And let me make sure I understand. You mean at the
14:05:08 Alaska Native Medical Center?
14:05:09 A. Correct.
14:05:10 Q. And so what were you verifying? That back in 2003,
14:05:16 there was not a neurosurgeon available at that hospital?
14:05:18 A. Well, that was my understanding all along. I just
14:05:21 wanted to verify that. So I asked her that this morning.
14:05:25 Q. And where did you get that understanding?
14:05:26 A. Probably in a phone conversation, you know, well a
14:05:30 long time ago.
14:05:30 Q. From who, of sorts?
14:05:33 A. Probably from counsel. But it's pretty clear
14:05:35 because of all the transfer, you know, issues involved that
14:05:38 they weren't going to deal with it there themselves anyway.
14:05:42 But somewhere along the line, I think counsel explained to me
14:05:45 what the limitations of the hospital were.
14:05:47 Q. And I guess how did you verify that information?
14:05:49 A. I took it at face value. I just verified it
14:05:52 verbally this morning with counsel.

14:05:54 Q. Oh. Okay. I'm sorry. I thought you called
14:05:56 someone or checked on it this morning.
14:05:58 A. No. This was in our meeting this morning.
14:06:00 Q. Okay.
14:06:01 Anything else in the way of additional information
14:06:04 or documents that you got this morning?
14:06:05 A. Not to my knowledge.
14:06:07 Q. All right.
14:06:07 I have a copy of your CV that was provided as part
14:06:12 of the disclosures in this case. Is that CV -- it's dated
14:06:18 July 1, 2004. Is it still accurate at this point?
14:06:22 A. I believe so, because I believe it's the one that I
14:06:25 furnished with the opinion letter of November of last year.
14:06:29 There haven't been any substantive changes in the last couple
14:06:31 of years.
14:06:33 Q. Okay.
14:06:33 And it indicates -- well, let me ask you directly.
14:06:36 What area of medicine do you consider yourself to be
14:06:39 specialized in?
14:06:40 A. In emergency medicine.
14:06:41 Q. Any others?
14:06:42 A. No.
14:06:42 Q. Do you have any particular specialty in the either
14:06:47 diagnosis or treatment of patients with subarachnoid
14:06:51 hemorrhage or aneurism?

14:06:52 A. Well, I have been the co-chair of the stroke
14:06:56 committee at our hospital for the last two years and I've
14:06:59 been active in developing the stroke team. In fact, I led
14:07:03 that development. We've just generated admitting orders and
14:07:08 protocols for our stroke patients including intracranial
14:07:13 hemorrhage. And I've been active in educating the staff and
14:07:16 the nurses on the issue of strokes. I participate in the
14:07:19 County stroke meetings. And I suppose at this stage in my
14:07:24 career, if you had to say what area am I most involved with,
14:07:27 that would be it.
14:07:28 Q. In the area of patients with strokes?
14:07:30 A. Correct.
14:07:31 Q. That -- my understanding includes patients who have
14:07:35 strokes for lots of different reasons, not just patients with
14:07:39 aneurisms.
14:07:40 A. That's correct.
14:07:40 Q. Okay.
14:07:41 And in terms of your prior experience, I take it
14:07:44 you had a general experience as an emergency room physician.
14:07:47 You weren't specializing particularly in the care of patients
14:07:50 who had aneurisms.
14:07:51 A. No. That's partly correct. I began out in
14:07:56 internal medicine, switched to emergency medicine, did my
14:08:01 residency there. And for the first five or ten years, my
14:08:04 area of interest was in trauma and hemorrhage. And I talked

14:34:31 1 Q. In this case, do you know or are you able to render
14:34:34 2 an opinion as to what size Mr. Allen's aneurism was?
14:34:37 3 A. No.
14:34:38 4 Q. I have also seen at least published data that
14:34:50 5 indicates some patients have more than one aneurism. Can you
14:34:53 6 tell whether Mr. Allen might have had more than one aneurism?
14:34:58 7 A. No, sir.
14:34:58 8 Q. Is it part of your area of expertise such that you
14:35:07 9 can render an opinion in this case as to whether – assuming
14:35:11 10 Mr. Allen had an aneurism, whether it would have been more
14:35:15 11 likely treated by a clipping procedure or by one of these
14:35:20 12 coiling procedures?
14:35:21 13 A. Yes.
14:35:22 14 Q. All right.
14:35:23 15 And can you tell me what your understanding is of
14:35:26 16 that or what your opinion is?
14:35:28 17 A. Yeah. And I base that on the fact that two or
14:35:31 18 three years ago, the coiling procedure was not very common.
14:35:36 19 And even now, in 2006, the clear indications and guidelines
14:35:43 20 are still being worked out and it's not an everyday
14:35:46 21 procedure. So in 2003, if there were going to be a procedure
14:35:49 22 done, it would much more likely be either a screw for
14:35:52 23 intracranial monitoring, a drainage of the hematoma if it
14:35:57 24 existed or clipping of an aneurism.
14:35:59 25 Q. Did Mr. Allen have a hematoma that would have been

14:36:03 1 drained.
14:36:03 2 A. No. Well, you know, I'd have to say I need to look
14:36:07 3 back at the CT, which I could do if you'd like.
14:36:10 4 Q. Sure.
14:36:12 5 A. Let's see here.
14:36:13 6 MS. MC CREADY: And actually, can we just go off
14:36:16 7 the record for a moment so I can take a bathroom break?
14:36:19 8 MR. GUARINO: Why don't we do that. I'm going to
14:36:23 9 stay on the line mther that call again. Why don't we take a
14:36:27 10 ten minute break.
14:36:27 11 MS. MC CREADY: Okay.
14:36:27 12 THE VIDEOGRAPHER: Going off the record at
14:36:30 13 3:36 p.m.
14:40:59 14 (off the record)
14:40:59 15 THE VIDEOGRAPHER: We're on record at 2:41.
14:41:05 16 MS. MC CREADY: And, Gary, this is Donna McCready.
14:41:07 17 I just wanted to – this might shorten the deposition some.
14:41:12 18 I want to be really clear. You know, Dr. Mannix is just –
14:41:16 19 I'm offering him as an expert on the standard of care. He's
14:41:19 20 not going to be rendering any opinions on causation. And I
14:41:23 21 probably could have saved you some time had I thought to say
14:41:27 22 that earlier. But consistent with his report, he's really
14:41:30 23 only – he's an expert in emergency medicine and, therefore,
14:41:34 24 testifying about the standard of care.
14:41:37 25 MR. GUARINO: Yeah. That will shorten it up. So

14:41:40 1 it will probably affect some of the questions I was going to
14:41:42 2 ask down the road. But let's see how it goes. If I get to
14:41:46 3 that point and he says he's not going to offer opinions in an
14:41:50 4 area, then we'll move on.
14:41:52 5 MS. MC CREADY: Okay.
14:41:56 6 BY MR. GUARINO:
14:41:57 7 Q. Are we ready?
14:41:57 8 A. We are. And I did locate the document about the CT
14:42:02 9 scan.
14:42:02 10 Q. Let me ask you a question on that, Doctor, just so
14:42:06 11 I can be clear. Is this the report of the CT scan that was
14:42:09 12 done at Providence Hospital when Mr. Allen was brought in?
14:42:13 13 A. That's correct.
14:42:14 14 Q. Have you ever seen the actual film of that CT scan?
14:42:16 15 A. No, sir.
14:42:17 16 Q. But you're looking at the report. And I think you
14:42:19 17 said you wanted to look at it to tell whether he had a
14:42:22 18 hematoma.
14:42:23 19 A. Yeah. My recall was that he did not and the report
14:42:25 20 is consistent with that.
14:42:27 21 Q. So he would not – at least in that report, he
14:42:30 22 would not have had on of the surgical procedures to drain a
14:42:33 23 hematoma?
14:42:34 24 A. Certainly not at the time this CT was done.
14:42:37 25 Q. All right.

14:42:37 1 And is there any reason to think that at an earlier
14:42:40 2 time that day, he would have had a hematoma?
14:42:43 3 A. No. Sometimes later if there's recurrent bleeding,
14:42:45 4 there could be one.
14:42:46 5 Q. And I think we may be able to end this fairly
14:42:46 6 quickly. But since I started, I'd like to fully close it
14:42:49 7 off. And I think you indicated that you thought back in 2003
14:42:52 8 the more likely procedure would have been the clipping type
14:42:56 9 procedure as opposed to the coiling procedure.
14:42:58 10 A. That's correct.
14:42:58 11 Q. Was that – just so I can – for my own mind, is
14:43:05 12 that anywhere? For example, if Mr. Allen had been here at
14:43:08 13 Anchorage or if he had been at a teaching hospital in
14:43:11 14 Los Angeles or in San Francisco, would that sort of general
14:43:14 15 rule, you think, still apply, that they would more likely do
14:43:17 16 a clipping procedure than a coiling procedure?
14:43:19 17 A. No. That's – I'm glad you asked the question.
14:43:22 18 When I say more likely, I mean statistically more likely
14:43:26 19 across the board, because the coiling was not done. If he
14:43:30 20 ended up at a center where there happened to be somebody that
14:43:34 21 was very interested and expert at it, then they may have
14:43:38 22 developed their own internal protocols and he might well have
14:43:41 23 had it done. Those protocols are still being developed and
14:43:43 24 there's not a consensus even now across the nation about the
14:43:47 25 clear advantages of one versus the other in every instance.

16:29:22 who's triaged at a level 2; is that correct?
16:29:25 A. As a general statement, that's probably accurate.
16:29:28 Q. And someone triaged at a level two, would, again,
16:29:33 all things being equal, would be expected to be seen sooner
16:29:37 than a level 3?
16:29:38 A. Well, that's partly true. But the triage decision
16:29:42 also has to do with the level of illness and the level of
16:29:46 evaluation required. So when you triage somebody – when we
16:29:50 do this in our emergency department, when you triage somebody
16:29:53 to the emergent side, you're saying this person had something
16:29:56 serious enough they needed to see a doctor. If they need to
16:30:01 see a doctor now, then that becomes – you move them up in
16:30:04 that range to a 1 or whatever that says they need to see the
16:30:08 doctor now. But the real triage decision is do they need to
16:30:11 see a doctor in the main ER and how soon.
16:30:13 If you triage somebody to the urgent care side,
16:30:16 you're saying, generally, they don't need to see a doctor
16:30:19 neeessarily and they don't need to be seen now. So you're
16:30:22 pretty much ruling out life threatening problems with that
16:30:25 triage decision.
16:30:26 Q. And I'm just focusing for the moment, I'll get to
16:30:29 the second part, on the question of how soon they're seen.
16:30:32 And maybe I can simplify this. Do you think there's any
16:30:35 causal connection as to indicate in terms of the time when
16:30:38 Mr. Allen was seen and his injuries in this case?

126

16:30:41 A. Well, let me refresh my memory about the times. I
16:30:45 think he was triaged at 7:10 and seen at 7:35. And honestly,
16:30:51 Counselor, that's good in any ER.
16:30:54 Q. So the fact that it took 25 or 30 minutes to see
16:30:57 him, that's not a problem that you're critical in the case?
16:30:59 A. It's not.
16:31:00 Q. Okay.
16:31:00 And I take it what you are critical of is the fact
16:31:04 that he was seen by a nurse practitioner as opposed to by an
16:31:08 emergency room physician?
16:31:09 A. Well, let me backtrack. What I'm really critical
16:31:13 of is the triage assessment itself which focuses again on his
16:31:17 recurrent pain problem and doesn't ask any of the key
16:31:20 question about differentiating – I mean, by her own
16:31:24 admission, it's a ten out of ten pain in the head and in the
16:31:29 ears. That in any emergency department is going to be
16:31:33 triaged in a fairly emergent way. But she asks none of those
16:31:37 questions, and it's very clear that she made some decisions
16:31:41 about him when she saw him based on the previous history.
16:31:45 She initially said, "He's in all the time. I see him all the
16:31:48 time." When she's pushed on that, the best she could come up
16:31:52 with was, "Well, I think I saw him when he came in with the
16:31:55 initial injury." And then she says, "I didn't really believe
16:31:58 that he was having as much pain as he said." Well, you make
16:31:58 those kind of assumptions at your own jeopardy. And none of

127

16:32:02 the other critical questions – what was the onset of his
16:32:04 headaches. Subarachnoids usually start right now. The
16:32:08 patient can tell you. That's not the way jaw pain starts.
16:32:12 Is this just like the pain you've had before? And we're back
16:32:14 into the same conversation. So there was a misevaluation and
16:32:17 triage. And a result of that was that he was triaged in a
16:32:22 way that he went to the nurse practitioner.
16:32:27 Q. And that part I understood. I guess I'm trying to
16:32:29 explore – I understand you're critical of that. But in
16:32:31 terms of practical results, I guess is what I'm looking at,
16:32:33 you're not critical of how long it took them to see him. So
16:32:36 I can set that aside.
16:32:37 A. That's correct.
16:32:38 Q. Now, in terms of who saw him, you're critical in
16:32:42 that you think he should have been seen by an emergency
16:32:47 physician, not by a nurse practitioner.
16:32:49 A. Well, what I'm saying is that their own internal
16:32:52 guidelines say that they should have been triaged to the main
16:32:56 emergency department. Now, category 3 makes – and he's very
16:32:56 clearly a category 2 in their guidelines. Category 3 makes
16:33:00 room for the possibility that if the triage is busy, a
16:33:03 midlevel practitioner would see that patient. But my review
16:33:03 of the log that day indicates that all the level 3 patients
16:33:07 were seen by doctors. So had the patient been triaged 2 or
16:33:24 3, a doctor would have seen the patient. And in my judgment,

128

16:33:24 although I think the standard of care still applies to the
16:33:24 nurse practitioner, I think the likelihood that this
16:33:24 diagnosis would have been or at least suspected was higher.
16:33:26 Q. And that's what I was trying to get to. Your
16:33:30 critique ultimately is that if a triage at 2 or 3 had been
16:33:32 seen by an emergency room physician as opposed to a nurse
16:33:35 practitioner, that it's more likely that he would have --
16:33:38 there would have ben a diagnosis of this subarachnoid
16:33:41 hemorrhage?
16:33:41 A. I believe so.
16:33:41 Q. Okay.
16:33:42 Now, before we get to that, is it – do you agree
16:33:45 that at any time if Nurse Feary had thought that he was more
16:33:50 seriously ill or that he should have been triaged at a higher
16:33:55 level of 3 or 2 or 1, she could have referred him or
16:33:58 consulted with emergent room physicians?
16:34:01 A. Absolutely.
16:34:02 Q. So it's not like you get triaged once and the game
16:34:06 is over, you never get a chance to see an ER doctor, shut in
16:34:12 to another facility for that initial term at all. It
16:34:17 indicates Ms. Nurse Feary assessed him. In her own
16:34:19 testimony, she said if she thought he was more seriously ill,
16:34:23 she could have consulted with a doctor; correct?
16:34:25 A. Correct.
16:34:25 Q. And you would expect a nurse practitioner, I take

129